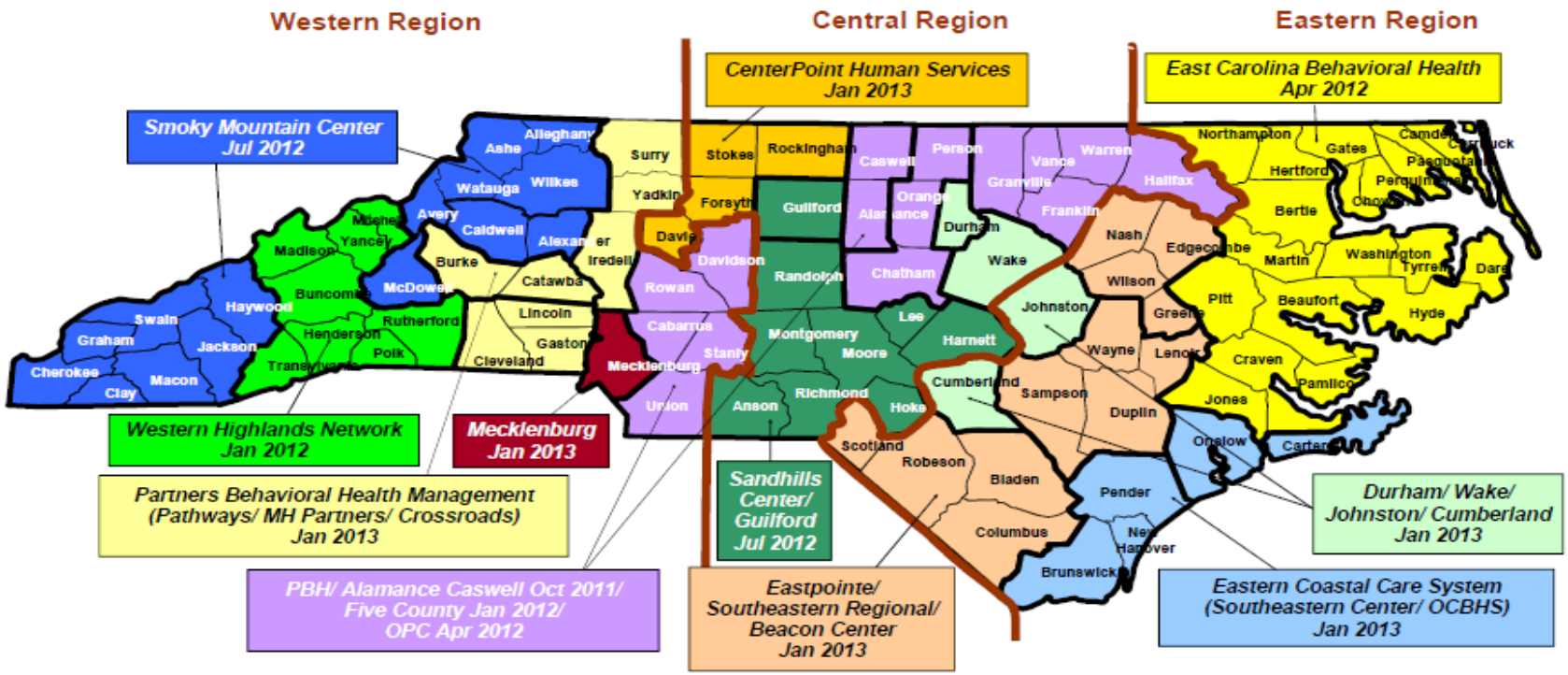
Smoky Mountain Center Report to the North Carolina General Assembly Joint Appropriations Subcommittee on Health and Human Services

Presented by
Brian Ingraham, CEO
February 27, 2013

Proposed Local Management Entity - Managed Care Organizations (LME-MCOs) and their Member Counties on January 1, 2013



Unless otherwise indicated, the LME name is the county name(s).
The lead LME name for the proposed LME-MCO is shown first.
Dates shown are the planned Waiver start dates.
Reflects plans as of February 9, 2012.

Information & Education

- Operations under the Waiver represent a different set of business practices, expectations and requirements
- These changes, which are showing better outcomes and cost control are challenging to adapt to
- Providing information and education to consumer members, providers and stakeholders on these changes, and explaining “what Smoky is doing” is an important part of our mission….

Monthly "Operations at a Glance" Report

Smoky Mountain Center (SMC)
Operations at a Glance – January 2013

SMC is committed to being a transparent organization and keeping stakeholders informed. To support these efforts, SMC will create a brief, monthly summary of operations by functional area.

Individuals Eligible for Medicaid Services through SMC

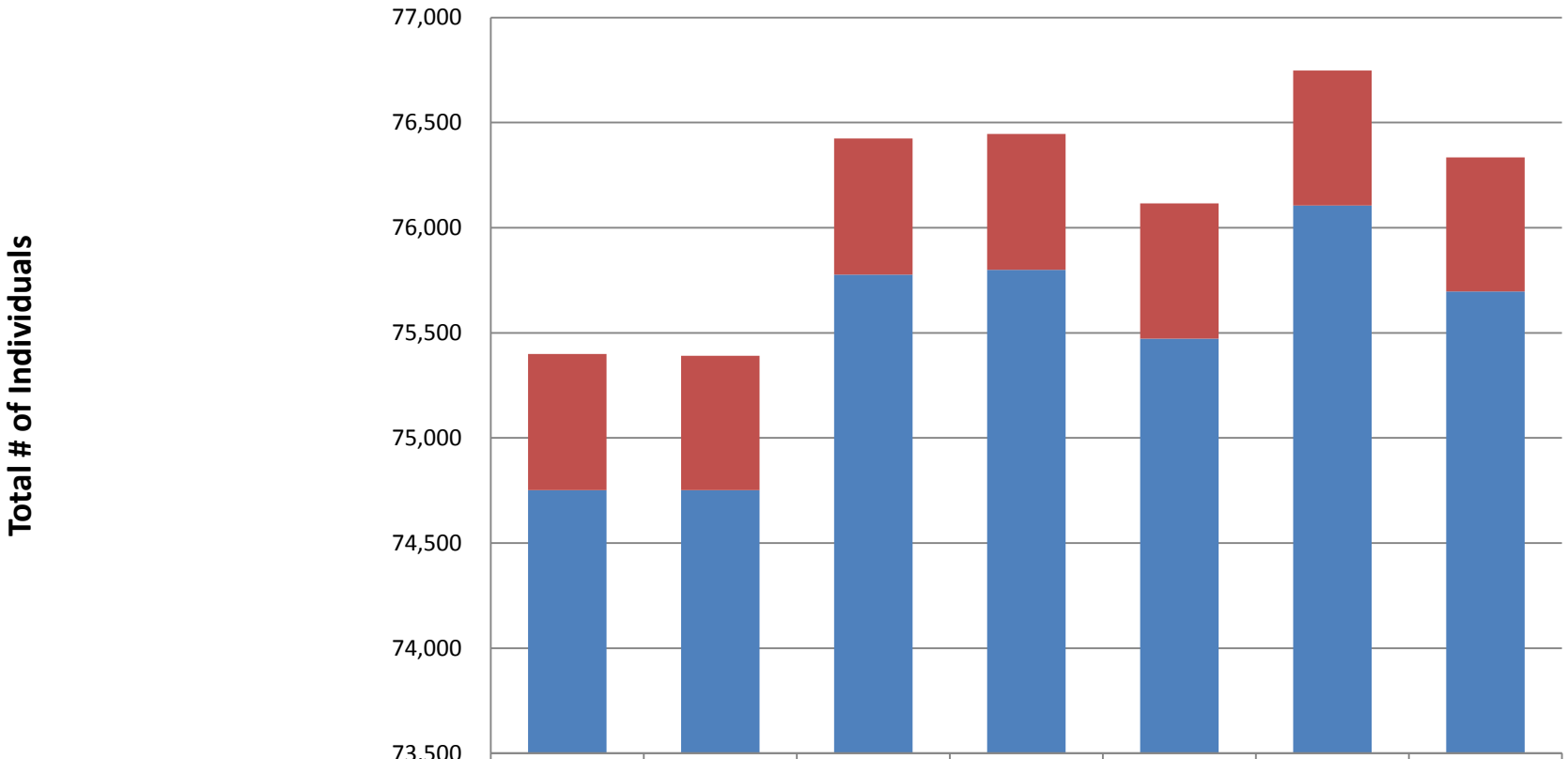
SMC is responsible for the oversight of behavioral health and intellectual/developmental disability Medicaid services in our 15-county area. For January:

- Individuals on the NC Innovations waiver: **638**
- Other individuals who receive Medicaid: **75,677**

Explanation: Each month the North Carolina Division of Medical Assistance (DMA) pays SMC a capitated amount per Medicaid recipient (numbers above). From those funds, we must manage services for any individual in SMC's 15 counties who needs a Medicaid service for mental health, intellectual/developmental disabilities, or substance abuse.

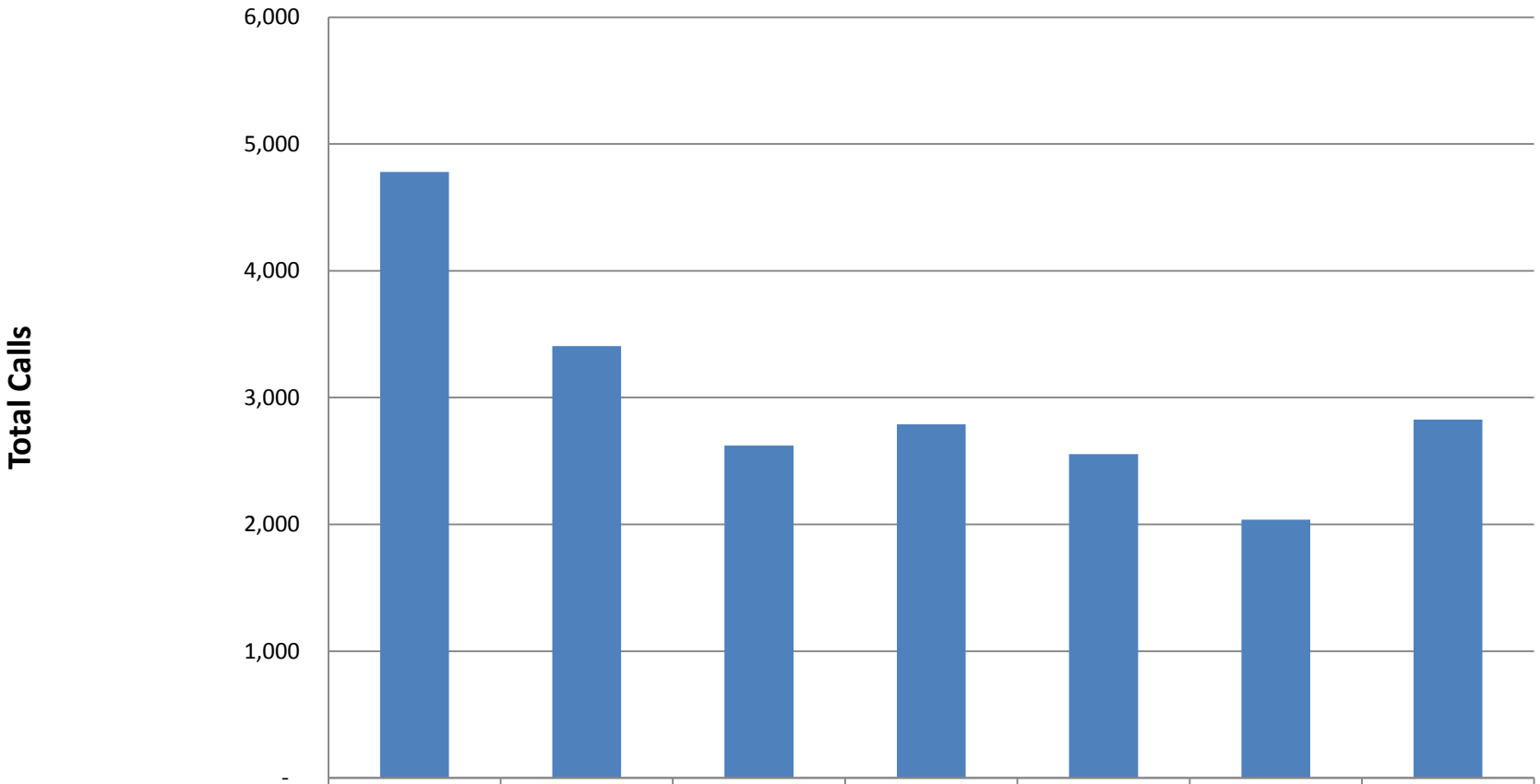
Customer Services (Medicaid and State-funded)

Individuals Eligible for Medicaid



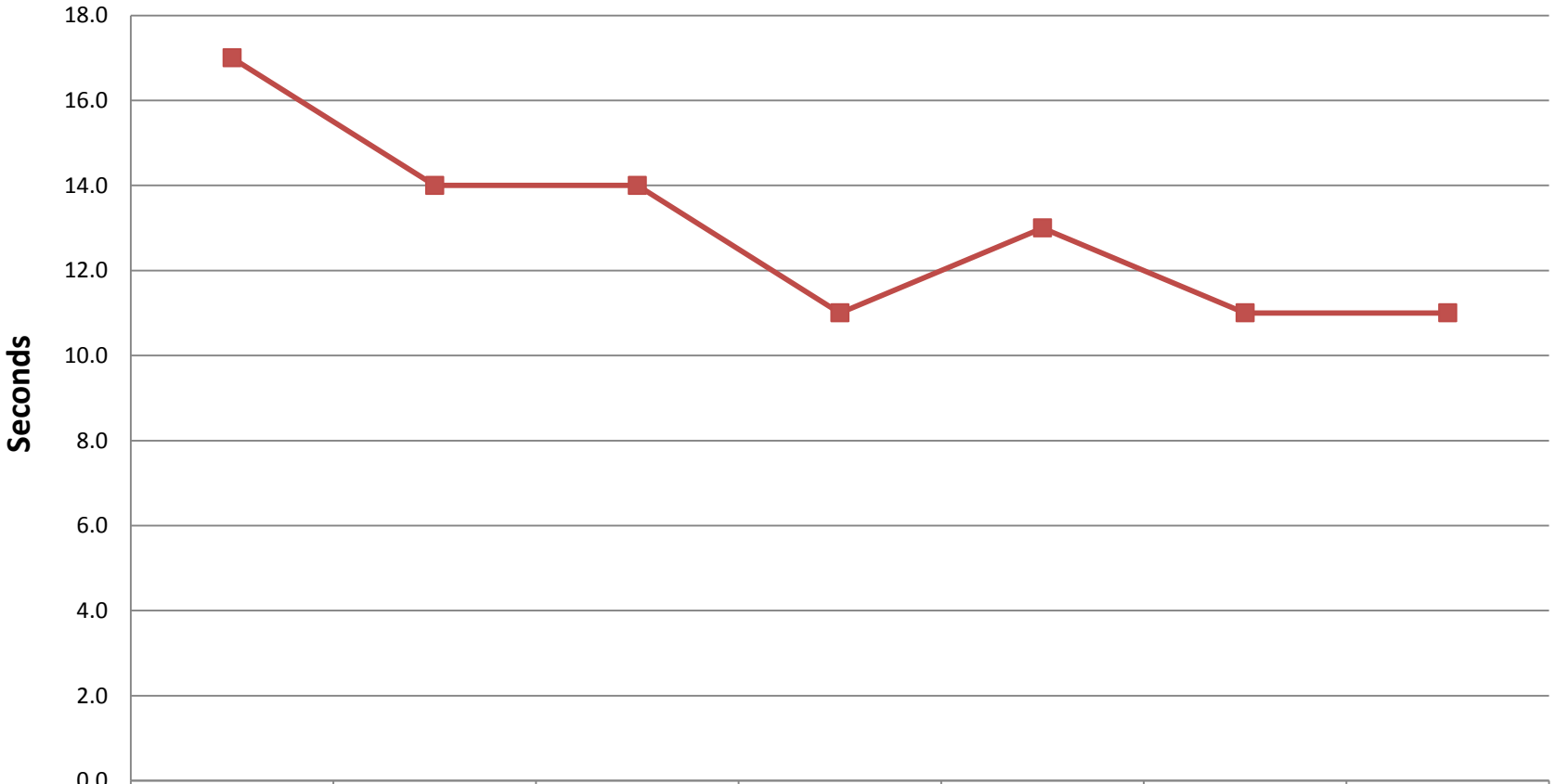
	July	Aug	Sep	Oct	Nov	Dec	Jan
Individuals on the NC INNOVATIONS Waiver	649	640	648	646	643	643	638
Others Who Receive Medicaid	74,751	74,751	75,777	75,800	75,472	76,105	75,697

Calls Answered by SMC Customer Services



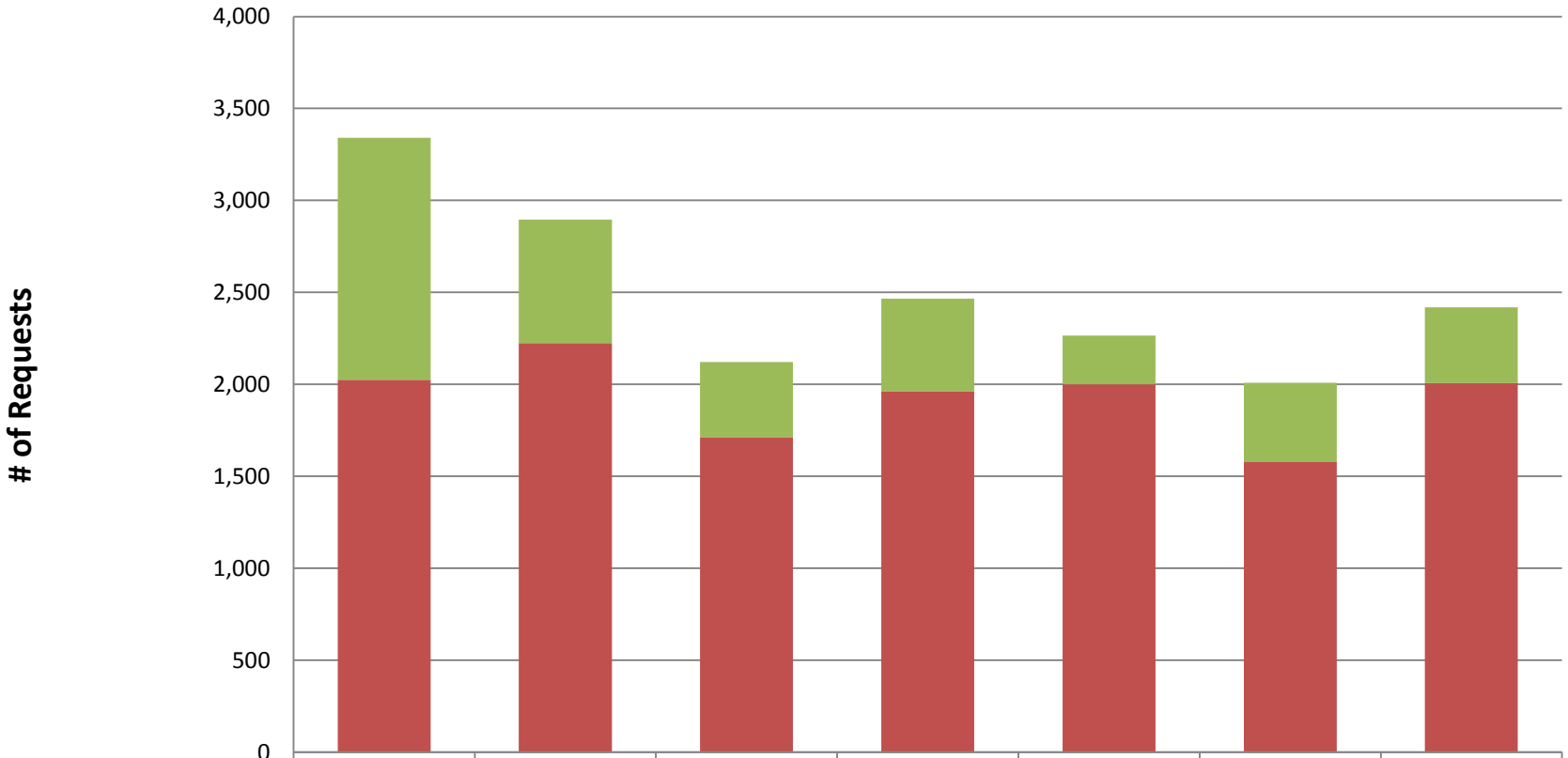
	July	Aug	Sep	Oct	Nov	Dec	Jan
Calls Answered by SMC CSRs	4,778	3,406	2,622	2,790	2,554	2,036	2,826

Average Time to Answer Calls (in seconds)



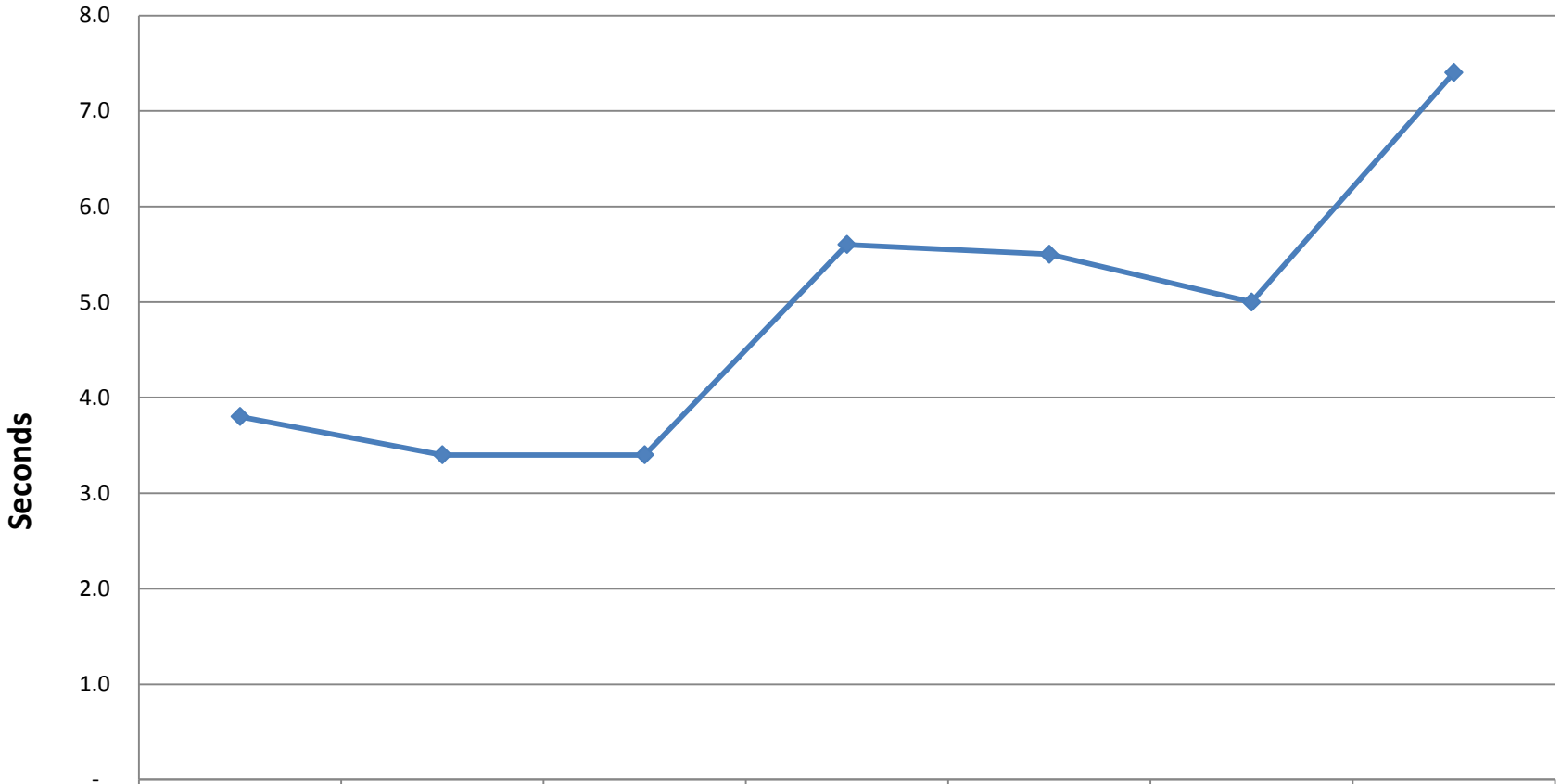
	July	Aug	Sep	Oct	Nov	Dec	Jan
Time	17.0	14.0	14.0	11.0	13.0	11.0	11.0

Approved Authorization Requests



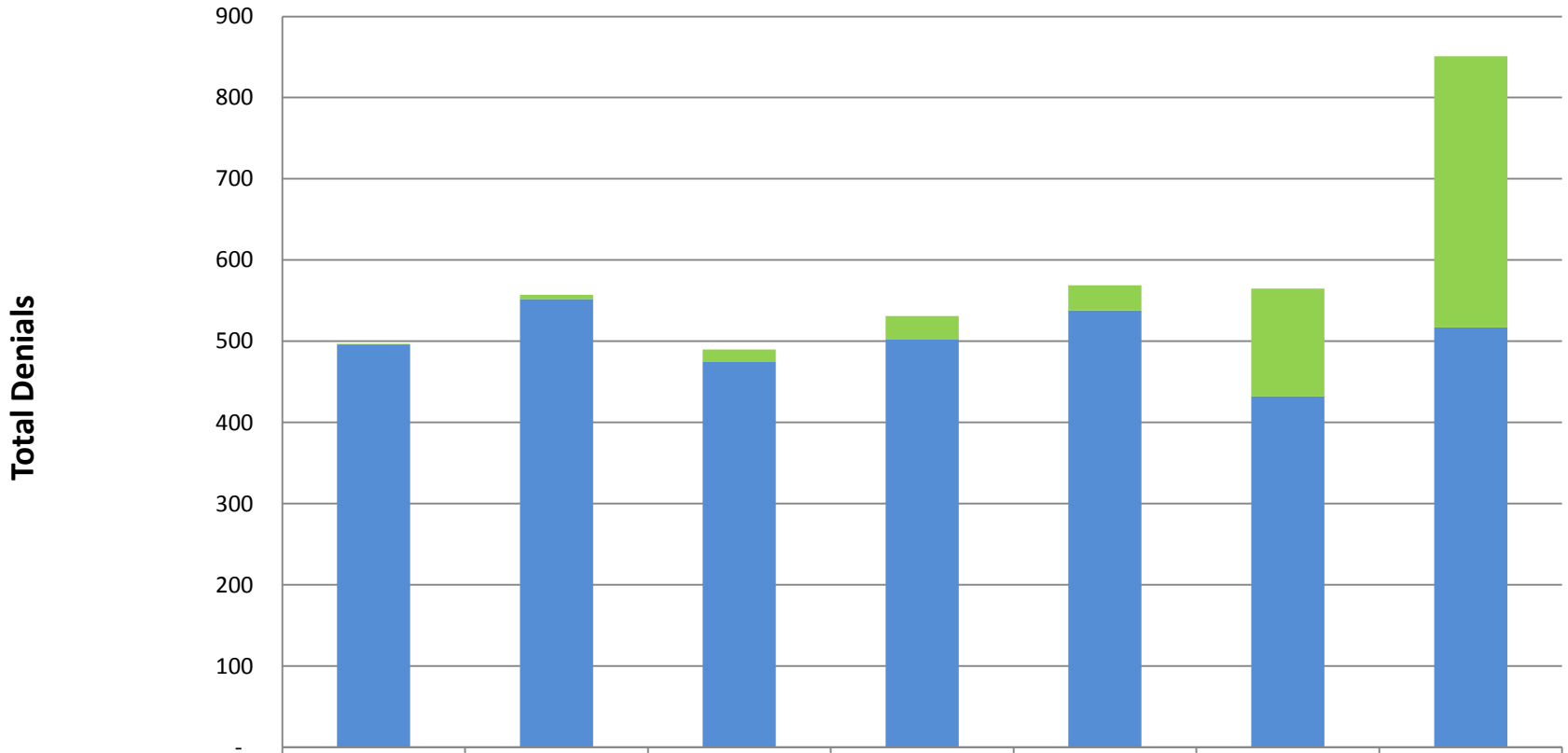
	July	Aug	Sep	Oct	Nov	Dec	Jan
I/DD Service Requests	1,315	672	409	503	265	429	411
MH/SA Service Requests	2,026	2,224	1,713	1,963	2,001	1,580	2,008

Average Time for Review of Authorizations for Care Management



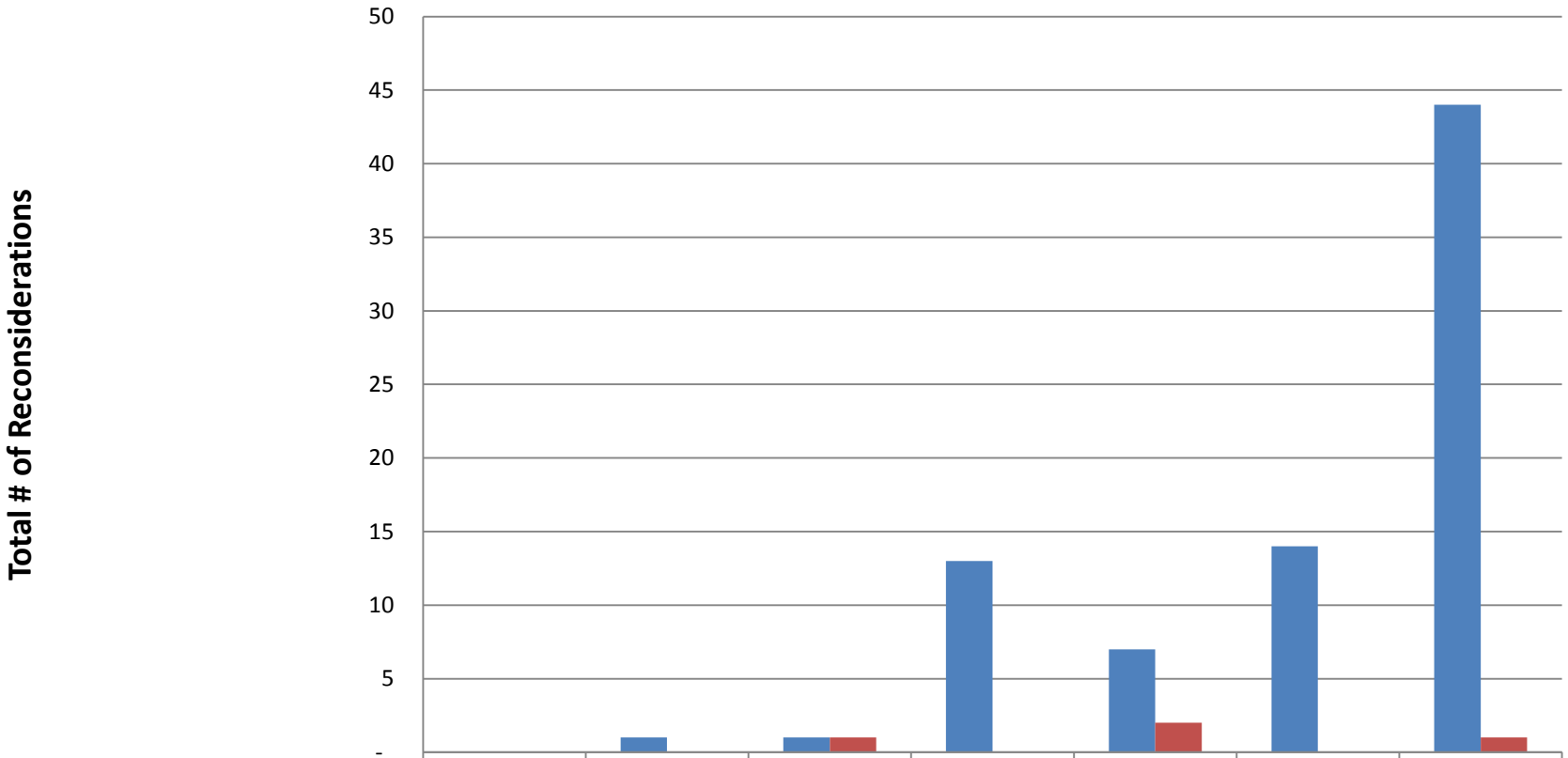
	July	Aug	Sep	Oct	Nov	Dec	Jan
Time	3.8	3.4	3.4	5.6	5.5	5	7.4

Requests Not Authorized
(Administrative and Non-Administrative Denials)



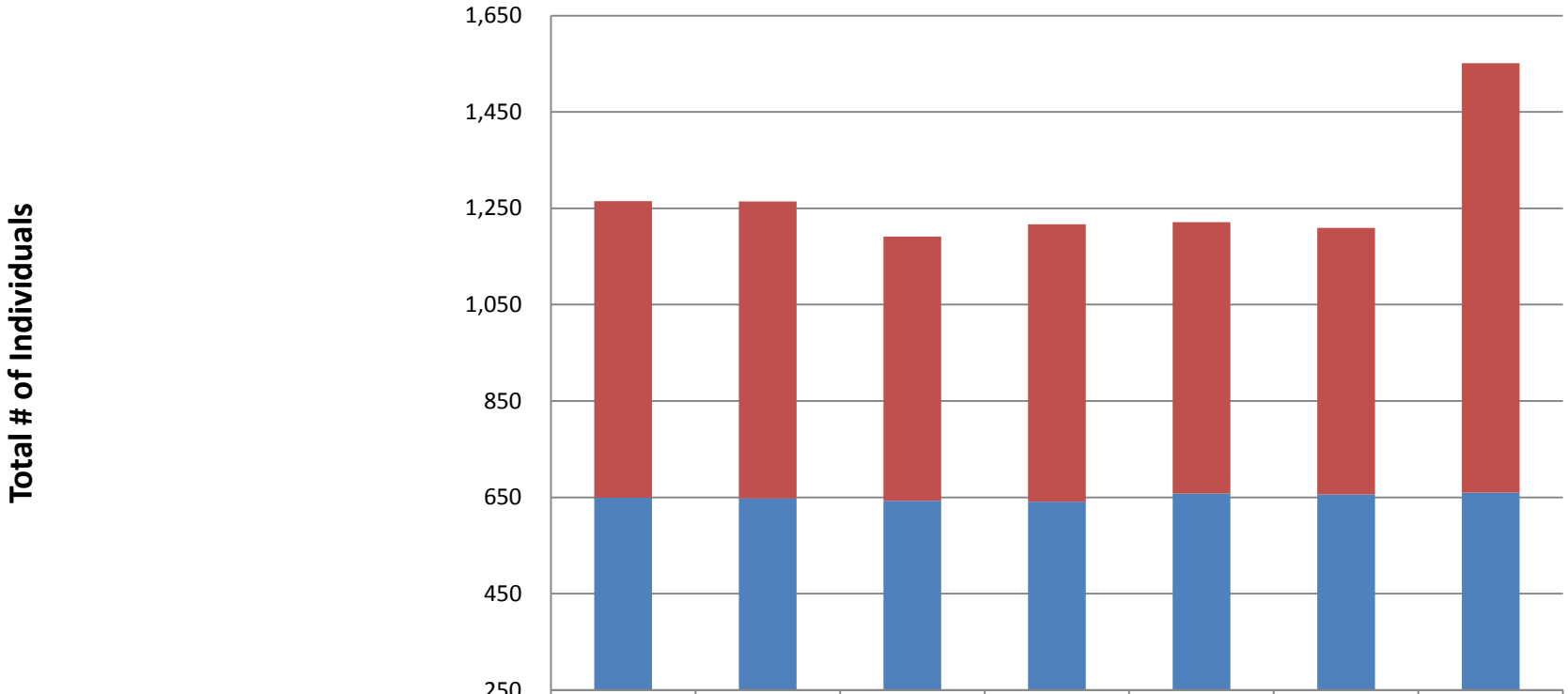
	July	Aug	Sep	Oct	Nov	Dec	Jan
Clinical Denials	1	5	15	29	31	133	334
Administrative Denials	496	552	475	502	538	432	517

Requests for Reconsideration/Appeals



	July	Aug	Sep	Oct	Nov	Dec	Jan
Reconsideration Requests	-	1	1	13	7	14	44
Reconsiderations Decisions Appealed	-	-	1	0	2	0	1

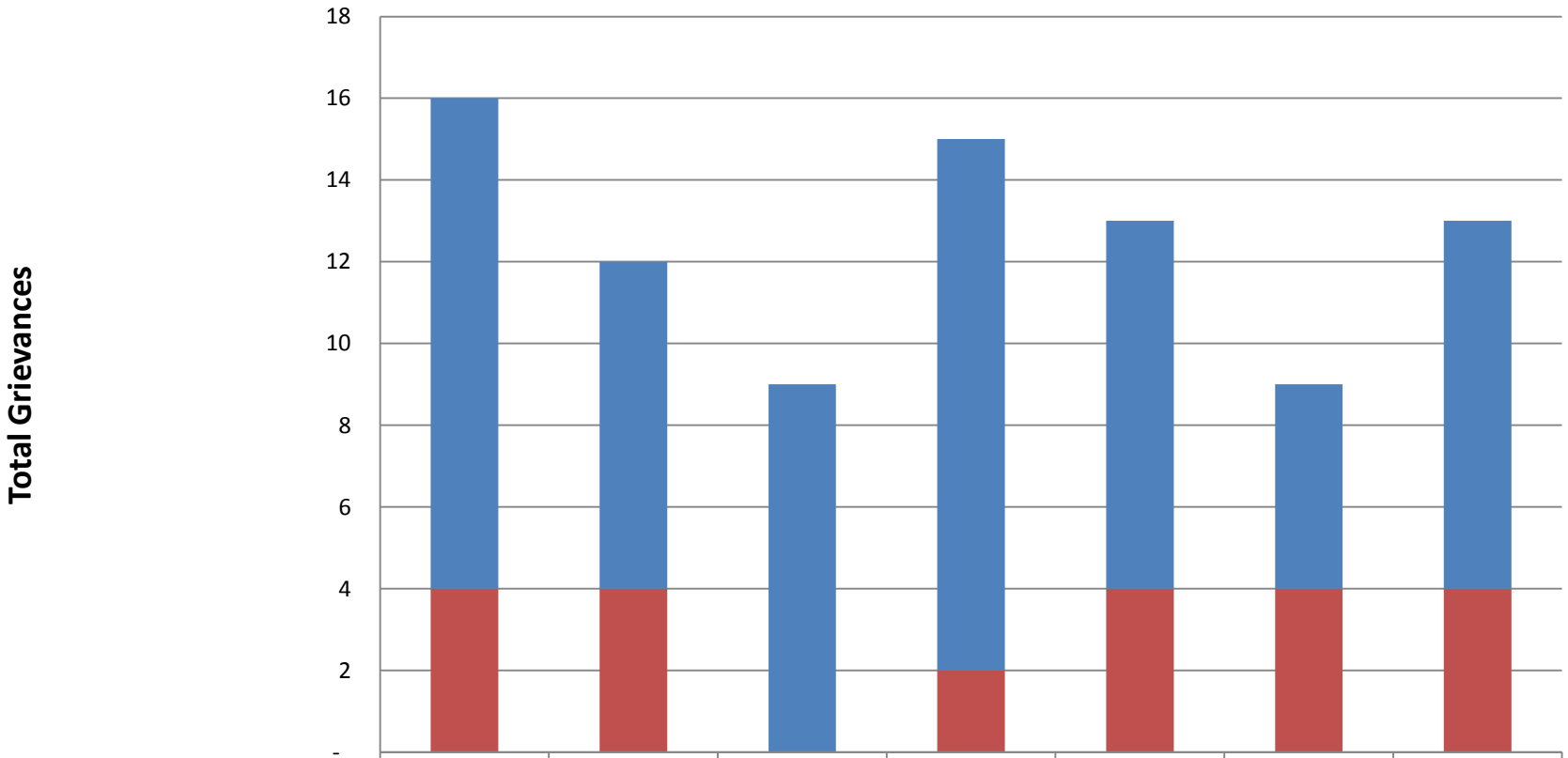
Care Coordination



	July	Aug	Sep	Oct	Nov	Dec	Jan
MH/SA "High Risk" individuals/Families Served by Care Coordinators	616	616	548	576	563	553	891
N Individuals/Families Served by Innovations Care Coordinators	649	648	643	641	658	656	660

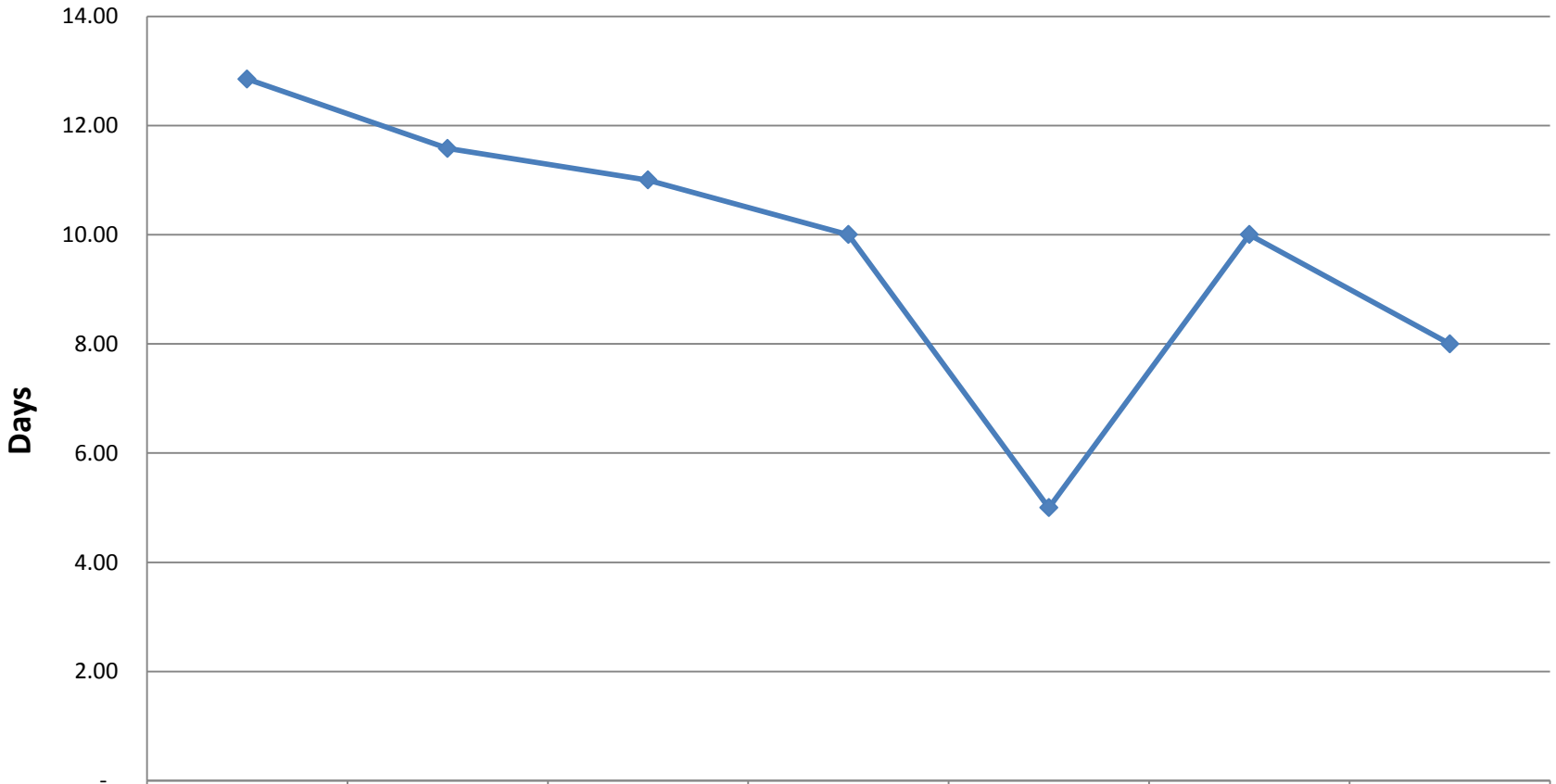
* Total numbers differ prior to January 2013 due to differences in reporting practices. Reporting prior to January 2013 occurred at the beginning of the month. Effective January 2013 totals were calculated based on caseload at any point during the month.

Grievances Filed



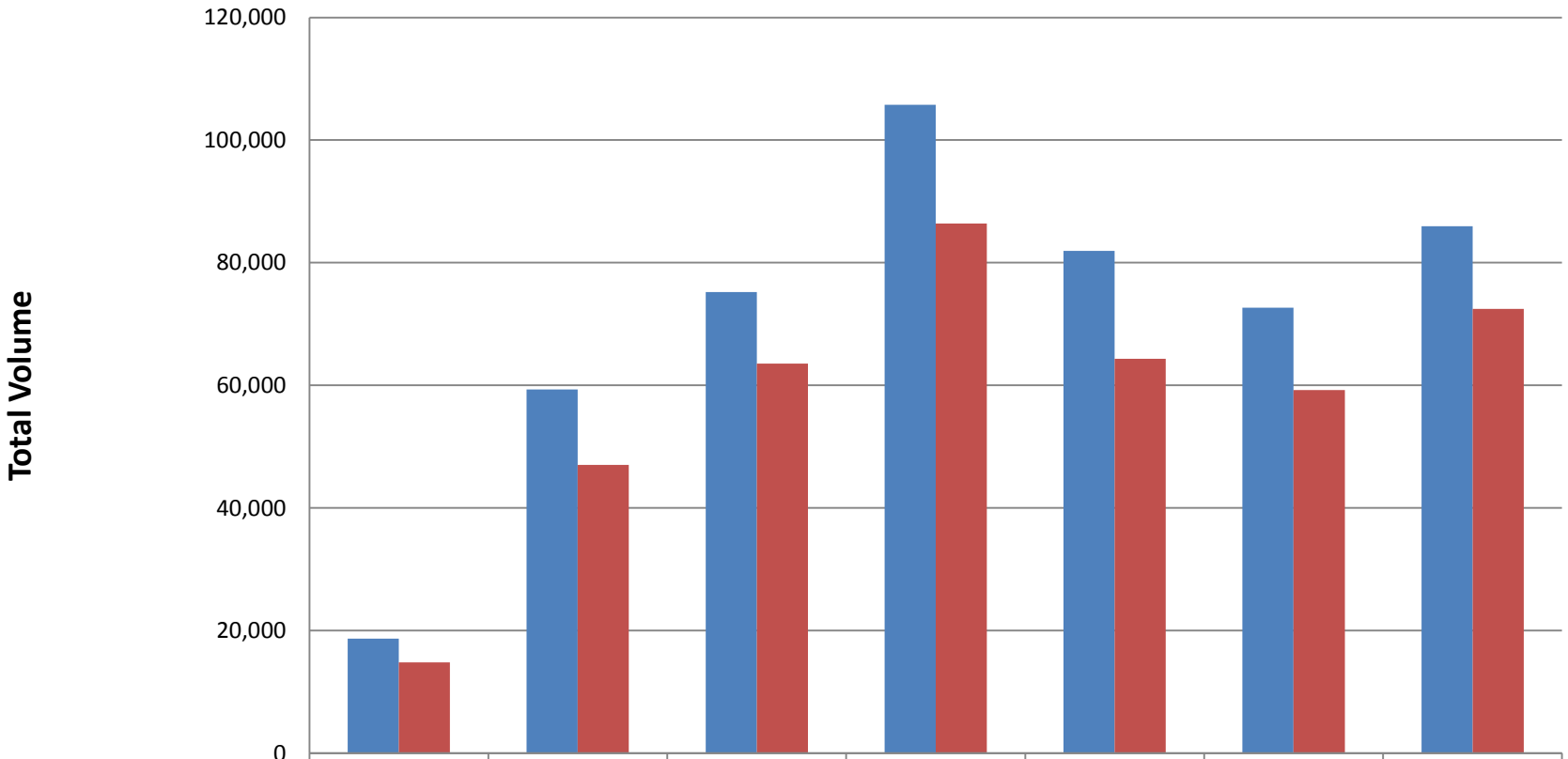
	July	Aug	Sep	Oct	Nov	Dec	Jan
Grievances Filed About Providers	12	8	9	13	9	5	9
Grievances Filed About SMC	4	4	0	2	4	4	4

Average Time to Resolve a Grievance



	July	Aug	Sep	Oct	Nov	Dec	Jan
Time	12.85	11.58	11	10	5	10	8

Claims Volume

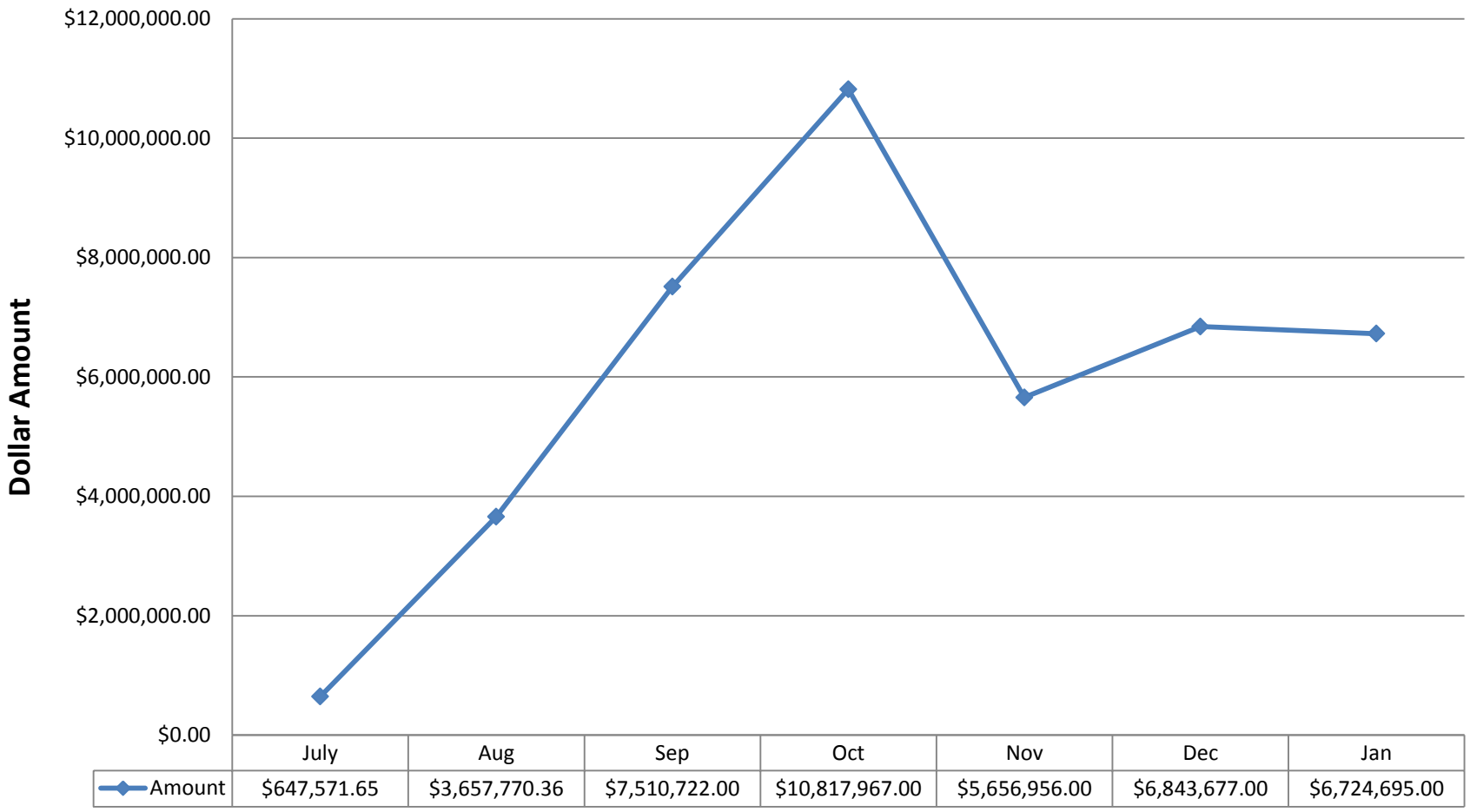


	July	Aug	Sep	Oct	Nov	Dec	Jan
Claims Processed	18,708	59,317	75,217	105,767	81,937	72,676	85,965
Claims Approved and Paid	14,799	47,042	63,533	86,401	64,338	59,259	72,462

Average Time to Process a Clean Claim

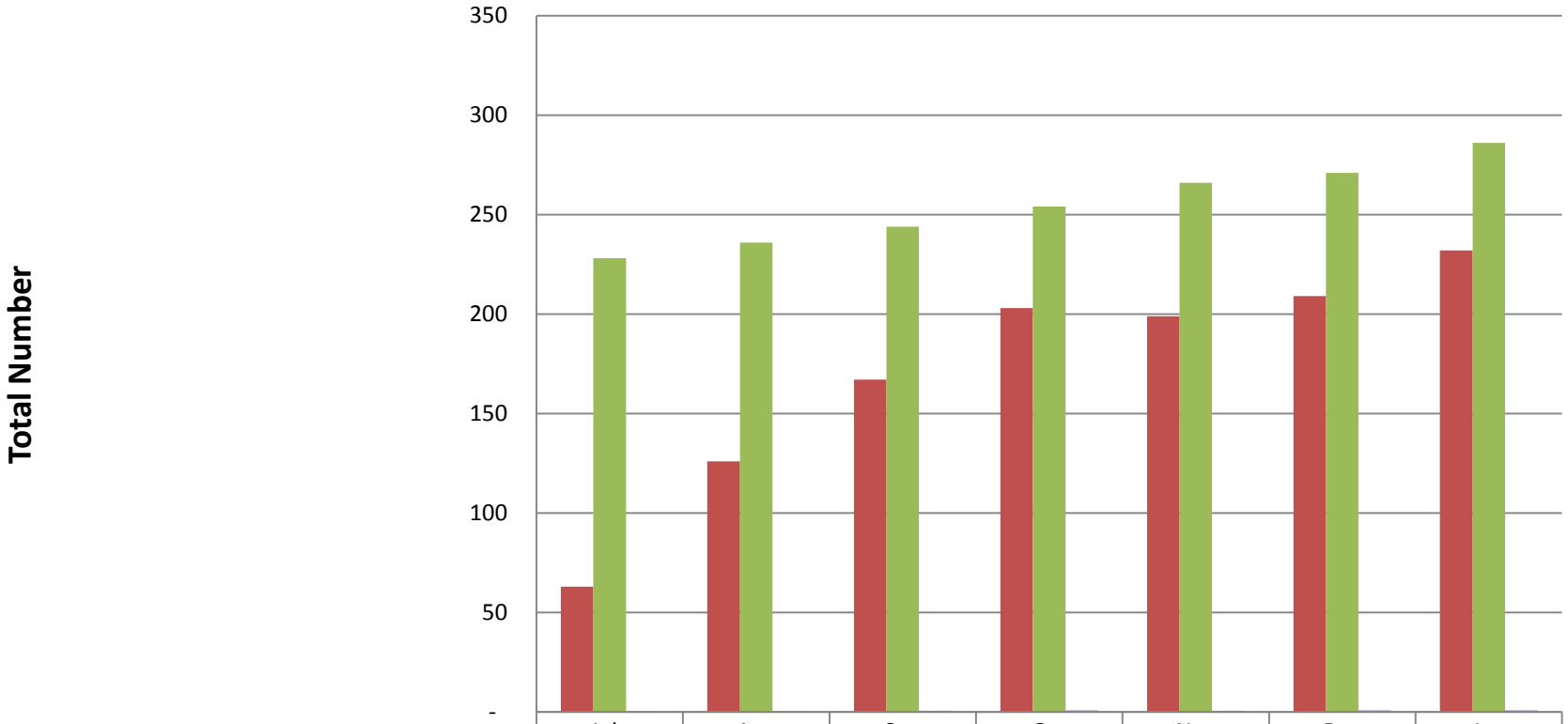
	July	Aug	Sep	Oct	Nov	Dec	Jan
Time	2.3	2.7	2.7	2.6	0.5	0.1	0.2

Total Medicaid Dollars Paid to Providers



	July	Aug	Sep	Oct	Nov	Dec	Jan
Amount	$647,571.65	$3,657,770.36	$7,510,722.00	$10,817,967.00	$5,656,956.00	$6,843,677.00	$6,724,695.00

Number of Providers Paid



	July	Aug	Sep	Oct	Nov	Dec	Jan
Number of Providers Receiving Claims Payments	63	126	167	203	199	209	232
Number of Provider in Network	228	236	244	254	266	271	286
Percentage	27.6%	53.4%	68.4%	80.0%	74.8%	81.1%	81.1%

* SMC contracts with six (6) single case agreement Providers.

SMC Efforts to Improve Outcomes for Youth: Managing and Coordinating Care for Children in Residential Settings

In the Beginning…

- On July 1, 2012, SMC received the ValueOptions® Psychiatric Residential Treatment Facility (PRTF) transition list, which identified specific children from the SMC catchment area residing in PRTFs.
- SMC Care Coordinators started immediate outreach to the eighty-one (81) children included on that list.
- SMC Care Coordination implemented standards that required all children in PRTF placements to receive face-to-face visits at least quarterly, and that SMC Care Coordinators would participate in all Child and Family Team meetings, regardless of location.

Level of Care and Lengths of Stay

Based on clinical documentation submitted by PRTF providers and information gathered at Child and Family Team meetings concerns emerged regarding the **level of care and lengths of stay .** This triggered an assertive record review for all consumers in PRTF placement, including:

- Diagnosis;
- Length of stay;
- Prior treatment history;
- Current interventions;
- Current behavioral symptomatology;
- Outcomes; and
- Clinical documentation to support level of care.

Consistent Standards & Expectations

SMC launched an interdepartmental work group to ensure consistency in expectations regarding authorizations, clinical policy, and medical necessity interpretation. Care Managers developed and implemented the following:

- Adherence to NC Division of Medical Assistance Clinical Coverage Policy 8D-1 for PRTFs;
- Development and implementation of Medical Necessity check sheets across all enhanced services, including PRTF; and
- Staffing of all residential cases with the SMC Chief Medical Officer.

Best Practice

- A cross-departmental clinical team reviewed national best practice to determine the most appropriate utilization of PRTF.
- Typically, PRTF is appropriate for short-term crisis intervention.
- Certain diagnoses may or may not benefit from the PRTF level of care (i.e. Conduct and Oppositional Defiant Disorders typically do not benefit).

Educating Providers and Stakeholders

- The team met with PRTF providers and stakeholders (Departments of Social Services, Department of Juvenile Justice and Delinquency Prevention) to provide information regarding best practice treatment models.
- SMC also related its plans to move forward in evaluating individual cases where children were placed in PRTFs, step down plans to community-based services where indicated, and how SMC will address service gaps in more rural counties for step down services.
- SMC staff supported PRTF providers by educating them about new SMC clinical practices and documentation needs for authorization of PRTF and other services in the child services continuum.

Improved Quality of Care

- SMC's efforts improved the quality of care for the identified children by matching their service level to their service need and integrating each child's treatment within their home community.
- Currently, only 22 children are in PRTF, compared to 81 at the outset.
- This community based treatment approach improves the likelihood for better long-term outcomes, and achieves significant reductions in PRTF expenditures (from approximately $776,000 per month to $264,000 per month).
- These savings have opened the door to support creative community based programming to divert high risk children from residential levels of care and to step them down to the community when out of home placement is appropriate.

Case Study #1

S is a 15 year-old male with diagnoses of Oppositional Defiant Disorder, Post Traumatic Stress Disorder, Sexual Abuse (perpetrator), and Depressive Disorder. He was in PRTF placement beginning in November of 2010 (slightly over 2 years), and likely would have remained there without Care Management intervention. This young man had no incidence of sexually inappropriate behavior for an extended period, and had developed a relapse prevention program. Care Coordination was actively involved with him at the facility. The SMC Care Manager staffed this case with the Chief Medical Officer who recommended discharge within 30 days of review. **S** stepped down to a lower level of care and has not required services that are more intensive.

Case Study #2

J is now eighteen and diagnosed with Oppositional Defiant Disorder and Polysubstance Dependence Disorder. She was in placement since March of 2012, and was involved with Juvenile Justice. The Care Coordinator reviewed her case and found that the consumer was stable in placement, and recommended step down to support and prepare **J** for aging out of the child system and back into the community. The Care Coordinator maintained connection with the Department of Juvenile Justice and the provider who would provide community services for J upon her return home. This team continued staffing **J**'s case while the Care Coordinator worked simultaneously with the facility to prepare a discharge plan. **J** has successfully stepped down to her father's home, receives Intensive In-Home Services, and is linked with an Independent Living Skills program.

Case Study #3

R is a 15 year-old female in DSS custody, placed in a PRTF and diagnosed with Conduct Disorder, Sexual Abuse, and Depressive Disorder. Care Management became aware of her case through Utilization Management's documentation review process. In the meantime, Care Coordination also began to question whether **R** could step down with the assistance of Child and Family Team involvement. The Care Coordinator facilitated discharge planning, as there were difficulties getting responses from **R**'s DSS Social Worker and the PRTF staff. Care Management did not support further authorization of PRTF due to the lack of medical necessity and based on information showing **R** could receive more effective treatment in a therapeutic foster care setting. Care Coordination worked with the residential facility to prepare an appropriate discharge plan and supported **R** in making a successful transition.

Questions?

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Smoky Mountain Center manages mental health, substance abuse, and intellectual/developmental disability services in the North Carolina Counties of Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga and Wilkes.

Toll-free Access to Services 24 hours a day, 7 days a week: 1-800-849-6127 (TTY calls: 1-800-855-2280)
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